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THE STATUS OF THE MEDICARE TRUST FUNDS

HEARING

BEFORE THE

COMMITTEE ON THE BUDGET
UNITED STATES SENATE

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THE STATUS OF THE MEDICARE TRUST FUNDS

THURSDAY, APRIL 22, 1999

U.S. SENATE,
COMMITTEE ON THE BUDGET,
Washington, DC.

The committee met, pursuant to notice, at 10:13 a.m., in room SD–608, Dirksen Senate Office Building, Hon. Pete V. Domenici (chairman of the committee) presiding.

Present: Senators Domenici, Gregg, Snowe, Frist, Lautenberg, Conrad, Murray, Wyden, and Feingold.

Staff present: G. William Hoagland, staff director; and Jim Capretta, senior policy analyst.

For the minority: Bruce King, staff director and Sue Nelson, director of budget review and analysis, senior analyst for medicare.

Chairman DOMENICI. The committee will come to order.

Some Senators that are here have to depart rather quickly for markups which are very important.

Senator Feingold, do you want to make an opening statement? You can proceed right now, and I will return in a minute myself.

OPENING STATEMENT OF SENATOR FEINGOLD

Senator FEINGOLD. Mr. Chairman, I appreciate that, and I particularly want to thank Senator Wyden, who was here before I was. I would ask if I could submit my questions in writing to the Secretary, whom I have already had a chance to speak with very briefly.

We do have a very serious problem with regard to the system in Wisconsin. I am deeply concerned about the future of medicare and feel strongly that we must work together to enact comprehensive reform. I have been working on medicare reform since I was first elected to the U.S. Senate in 1992, and what I have seen in Wisconsin and what I have heard from my constituents illustrates to me the serious need for reform, particularly with respect—and this is what I want to emphasize today—with respect to regional inequalities in payment systems that result in compromised access to care.

In fact, Senator Wyden, who has been so courteous to me this morning, has been, I think, the leading voice with regard to this issue overall.

As many of you know—and, of course, the Secretary, whom I would like to greet, knows Wisconsin as well as I do—Wisconsin has been a high-efficiency, low-cost medicare provider. In fact, if you calculate how much medicare spends per enrollee, Wisconsin's

medicare payments are among the lowest in the Nation, about $3,800 per enrollee, and that is 24 percent less than the national average of about $5,000. This disparity applies across all medicare services, and it is getting worse.

Programs in Wisconsin have operated so efficiently that there is very little or no fat to cut. Access to much needed services is being seriously compromised, particularly in rural areas, and the impact on my constituents who rely on medicare is absolutely devastating. And I would not use that word lightly. I have been working on these issues for 17 years, and I have never heard these providers more worried, more concerned, and more able to document the negative impact that is occurring.

The interim payment system for home health, which penalizes efficient providers by pegging their payments to past spending, has resulted in the closure of at least 24 home health agencies in Wisconsin, affecting 19 counties. Health department directors in Douglas County and Barron County in Wisconsin have contacted me to say that because of IPS cost limits, the county health departments actually owe hundreds of thousands of dollars to HCFA because the health department has provided services beyond the cost cap.

When I hear about situations like these, it is less surprising that 8 of the 24 closures in Wisconsin are actually county-run agencies. As a result of low beneficiary caps throughout our State, the home health care agencies that remain can't take up these patients without incurring serious financial losses, leaving beneficiaries in the area without access to home health care. These patients end up being hospitalized when they have an acute medical episode like a stroke or a diabetic shock or heart attack.

And then to make it worse, my constituents are also telling me that the PPS, the prospective payment system, for nursing homes doesn't adequately take into account the care of medically complex patients. One facility, the Bethany St. Joseph Care Center in La Crosse, Wisconsin, is one of the only medicare-certified ventilator-dependent programs in the State, and it has been forced to stop new medicare admissions because it is losing almost $300 per day on each ventilator-dependent medicare resident. The few remaining home health care agencies in the area cannot afford to care for these patients either.

So what happens? Well, a social worker at Gunderson Lutheran Hospital in La Crosse told me that because no nursing homes or home health care agencies can accept ventilator-dependent patients, patients are stuck in the intensive care unit. The hospital literally has no place to discharge these patients to.

Home health care agencies and nursing homes in Wisconsin are now having to send their patients to the hospital ICU because they can no longer afford to provide many of their services.

The Medicare System has unfairly penalized Wisconsin for providing cost-efficient care, and the result is costly indeed. We are hospitalizing patients who should be getting care at home and cutting patients' access to the cost-efficient, compassionate care that home health care agencies can provide.

Mr. Chairman, I realize that you have been courteous to me and so has the Senator from Oregon, so I will simply ask that the remainder of my statement be placed in the record, and I rarely

would ask for this kind of dispensation, but this is truly a crisis in our State and some other States. And I appreciate your courtesy and the Secretary as well, and we will submit the questions in writing.

Thank you, Mr. Chairman.

[The remainder of Senator Feingold opening statement follows:]

I think everyone can agree that the ICU is an appropriate environment to be providing long term care, but low payments in so many sectors put the sensible, responsible options out of reach.

What was seemingly just a series of payment changes has actually resulted in many of my constituents being denied a choice because home care and nursing home care is not available. The experience we in Wisconsin have had with across-the-board programmatic cuts that don't take existing regional disparities into account demonstrates the need for real reform in medicare.

As we work to enact meaningful, comprehensive medicare reform, we must address regional disparities in payments, we must change this system of penalizing providers who have practiced efficient, low-cost care, and we must ensure that all medicare beneficiaries have access to the services they need. We must enact policy that enables health care providers and patients to choose the most sensible and compassionate methods of care for our frail elderly.

We cannot extend solvency and achieve savings on the backs of people and programs least able to afford it. Across-the-board programmatic cuts that hurt access to vital services are not a substitute for reform.

I look forward to this morning's opportunity to discuss these very important issues, and to work with my colleagues to ensure access to services.

Thank you, Mr. Chairman.

Chairman DOMENICI. Thank you, Senator.

Are there any other Senators who would like to make some opening remarks? I have to leave at 11:00, so I need to get a few questions in. But I would like you to go ahead if you want to, Senator.

OPENING STATEMENT OF SENATOR WYDEN

Senator WYDEN. Thank you very much, Mr. Chairman.

First, Mr. Chairman, let me commend you for holding this hearing. You and I have talked often about the importance of health with respect to the budget, and I just appreciate your taking the committee in this direction and look forward to working with you.

I also want to say that it is a pleasure to have the Secretary here. You know, we always disagree on one issue or another, but the Secretary consistently stands up for people who don't have power and is willing to pursue fresh, creative solutions to health issues.

In our part of the country, I remember when she approved the Oregon Health Plan. The left wing didn't like it because they didn't think it was enough. The right wing didn't like it because they thought it was too much. She approved it, and now 100,000 low-income Oregonians who used to have nothing have a decent package of health benefits. And it was because we have a Secretary with some guts, and I appreciate it and look forward to working with her.

Madam Secretary, this morning I am interested in exploring two areas with you. The first deals with this prescription drug issue that is so important to the Nation's elderly. We have got more than 20 percent of our senior citizens who are spending something like $3,000 a year out-of-pocket on their prescription medicine. They really get hammered twice. They can't afford their medicine, and they pay a premium when they walk into a drugstore because

somebody who belongs to an HMO plan gets a discount because they are able to buy in bulk.

Senator Olympia Snowe and I on a bipartisan basis got 54 votes on the floor of the Senate to have a tobacco tax in order to start a pharmaceutical benefit for low-income older people. We are looking at using the Federal Employee Plan as a model for the delivery system, and when we get to some questions, I would like to explore that topic with you. And I know the Administration is working on it.

The second area, Madam Secretary, very briefly, that I would like to pursue with you is, as you know, 400,000 older people who are part of HMO medicare plans lost coverage last year, including many in the Pacific Northwest. In another couple of months, there are reports that we may have hundreds of thousands of additional older people losing coverage under those health plans. I know you have an interest in this subject, and I will want to explore with you steps that I think are going to need to be taken late this spring in order to protect those seniors.

We are having discussions about medicare and a crisis down the road in 2008 or 2006. This is going to be a crisis, I suspect, in another 6 weeks. So I look forward to working with you, and particularly exploring this morning the prescription drug issue and the question of what we do with respect to those plans. The Chairman and I are in States where the plans have historically been underreimbursed. So if those plans leave, it is very likely that it is going to be New Mexico and Oregon and Washington where we lose coverage, and I look forward to exploring that with you.

I thank you for the time, Mr. Chairman.

Chairman DOMENICI. Senator Gregg.

Senator GREGG. I have no opening.

Chairman DOMENICI. Senator Murray.

OPENING STATEMENT OF SENATOR MURRAY

Senator MURRAY. Thank you, Mr. Chairman. And I do have to go to another hearing on education, so I appreciate this opportunity, and let me just submit my statement for the record and thank the Chairman for having this important hearing and the Secretary for being here to discuss probably the most critical issue facing many of the citizens in our State.

I want to commend Senator Wyden for his work and echo his comments that he just made. In addition to that, although I can't stay, I would like to continue to work with you, Madam Secretary, on the issue of prevention and medical technology, because in the Trustees Report, they point out that medicare costs are increasing both because new, more expensive and effective medical technology is being developed every year and because of the health care needs of an aging population.

We have worked very hard to make sure that prevention is part of this because we know in the long run it does save dollars, and I would like to discuss with you and hope you comment today on their comment. I think it is not wise to simply say that medicare costs are increasing because of the availability of more effective medical technology. I think we have to take into account that if we have preventive care, if we have better technology today, that it

will save money in the future. And I hope we can explore that with you.

So thank you, Mr. Chairman, for having this hearing.

OPENING STATEMENT OF CHAIRMAN DOMENICI

Chairman DOMENICI. Madam Secretary, I want to welcome you today. I am sorry you have had to wait so long. I was at another subcommittee hearing this morning, and I couldn't get out any sooner. And we will try not to keep you too long this morning because you have a lot of serious business.

I think you know that your Department is one of the most important domestic policy agencies in this Government with very significant budgetary resources. In fact, in the 1999 budget, HHS outlays are expected to be about $375 billion, over 20 percent of the entire Federal budget. I am sure some of those are automatic entitlement kinds of expenditures, but you have a very, very big impact on the social structure of our country, especially in the area of health.

So I am pleased that we have an opportunity to review with you the status of the largest program in your department, medicare. I have been working on budgets for a long time, and it goes without saying that one of the most difficult budget issues that we have ever faced in the last three decades has been the rapid growth in medicare spending. And this predates the demographics when we soon will have many, many more seniors come in because of the baby-boom generation.

Between 1970 and 1997, medicare spending grew from a $6 billion program to $190 billion, for an average growth of 13.5 percent. Now, it is obvious, as you look at budgets with 13.5 percent increases, which were predominantly for costs of delivering health care, that could not continue on forever. In almost every piece of budget legislation, including the laws passed in 1981, 1983, 1987, 1990, 1993, and 1997, medicare reform has been a big part of the discussion because it has been a big part of the growth in budgetary expenditures.

But it is amazing. In the last 18 months, medicare spending growth has slowed dramatically—in fact, I must say, in a totally unprecedented way.

In 1998, medicare spending grew only 1.5 percent. Now, that is interesting because I just told you the average prior to that since 1970 was 13.5 percent versus 1.5. For the first 5 months of 1999, medicare spending is actually running well below the 1998 level. So it might not even be growing at 1.5 percent.

There should be no doubt that much of this is good news. After decades of spending growth at 3 times the National rate of inflation, we could perhaps celebrate a period of flat spending for that program. However—and we should take some credit for that. Most of that belongs in this instance to the Balanced Budget Act which we worked so hard to put together in 1997, which included the most significant reforms in medicare ever passed by Congress.

And that must be working in terms of cost control. With medicare spending growth down and revenues up, the Medicare Hospital Insurance Trust Fund is now projected to remain solvent until 2015, a full 7 years longer than projected in the 1998 Trustees Report.

I want to be clear, however, that I do not believe we can rest on this good news. Medicare funding imbalances remain severe over time, and spending growth under current law will far exceed the growth of the economy or tax income. And over the next 50 years, obviously, for a variety of reasons, spending is expected to grow from 2.5 percent of the gross domestic product to 5.3 percent. And, strangely enough in 75 years the HI payroll taxes will cover only about one-half of the HI expenditures in fact, we leave all of the sources of revenue as they are.

So I think it is important to continue with bipartisan discussions on how we can do better by this program. I want to commend those who have worked diligently to try to come up with a new plan, and I would hope that even though the Commission ended up in a disappointment because the requisite supermajority was not met, I remain hopeful that the Finance Committee can work with Secretary Shalala and others in this Administration to produce a bipartisan plan.

Now, let me turn to a couple of problems that we are having even though the good news is the flattening of the cost increase.

It should come as no surprise that this legislation, as complex as that which we put in the Balanced Budget Act, may require us to revisit some provisions that are producing some unintended consequences and outcomes. Let me mention two, and then if we have time, I will ask the Secretary about two or three others.

First, I believe the Medicare Plus Choice Program is the foundation for further medicare reform. But I am concerned that some of the payment changes in the BBA and the way they have been interpreted by your Department and HCFA may be unintentionally driving plans and beneficiaries out of Medicare Plus Choice and back into the Fee-for-Service Program. Specifically, the way the Administration has implemented the so-called risk adjustment on top of the payment rate changes required by law may actually promote fee-for-service at the expense of Medicare Plus Choice, which is not what Congress intended. And I am hopeful you will be able to address that issue.

Second, I believe we have a crisis brewing in the nursing home industry that I believe can be tied to payment changes in the BBA. Now, we have not been successful yet in convincing either HCFA or your Department that much of the nursing home dilemma in terms of financial ability to continue to serve—many of the big companies are on the verge of going broke. We have been unable to convince the Department that something is wrong with the way we are figuring cost reimbursement to them.

Now, if it requires that we do something, we ought to be told that. If it can be done by regulation, we ought to do it that way.

We had expected to save $9.6 billion, I say to my friends, in skilled nursing payments over 5 years. However, after the HHS issued regulations implementing the changes, CBO now projects skilled nursing spending will be well below earlier projections by multiple billions of dollars. In other words, that business and those nursing homes, be they individual or large corporations, are saving far more than was ever projected in the BBA, and that has got to mean something. It has got to mean either that they are so flush with money that this is justified, or we have in some way miscalcu-

lated and we are going to lose a lot of nursing homes. And if we have time, I will tell you that I am a little concerned, and I will later read some things from your Department which would indicate your Department seems more worried about filling the gap if they go bankrupt than trying to help get out of the dilemma.

I am very worried and concerned about that we might have overshot the mark in this area, and as a consequence, we may be on the verge of many closures of nursing homes with grave potential consequences to the beneficiaries.

I know that these issues are generally left to the HCFA administrator, but I hope Secretary Shalala can give us her current thinking on these issues.

Senator Lautenberg.

OPENING STATEMENT OF SENATOR LAUTENBERG

Senator LAUTENBERG. Thanks very much, Mr. Chairman, and I welcome Secretary Shalala.

I do want a moment to mention a function that took place last night where the Chairman was extolled, sainted, and I would say almost reverently talked about, all of which is stretching the truth but, nevertheless—— [Laughter.]

It was all said in public. But it was quite a distinguished audience. We had the Chairman of the Fed Reserve. We had former OMB Directors, former CBO Directors, and other distinguished guests and speakers, and they all had very complimentary things to say about our Chairman. And even though those of us who occasionally disagree—it is hard to remember the last time, but I think it was yesterday. But the fact of the matter is that we have established a good, hard-working relationship and a personal respect and allegiance to one another.

And I do want to say that our chief of staff, Bill Hoagland, last night made some of the warmest compliments about a boss, if I can say, that one would hear. He read directly from the prepared statement you had given him word for word. [Laughter.]

But it was heartfelt, Bill, and it was very nicely done, and my respects and appreciation to you as well.

Chairman DOMENICI. Senator, thank you for your kind remarks last night. I appreciate it very much.

Senator LAUTENBERG. We enjoyed the chance to talk in a more relaxed atmosphere and not worrying about pulling one another over the line.

Mr. Chairman, we have in front of us the Secretary, who has worked hard, provided leadership, and I commend you, Secretary Shalala, for your constant appearances when it had to be to learn what was going on, to come to States like New Jersey and other places where you wanted to witness or see the problems firsthand and take in what you saw and try to apply to them ever more limited resources and more expanded need. And I thank you, and I again note the great job that you have done.

Mr. Chairman, last month, the medicare trustees reported that the Medicare Trust Fund's life has been extended until 2015, a full 7 years longer than projected only last year. This was good news, and it suggests that the hard choices we made in 1997 in the bipartisan balanced budget agreement have yielded real savings.

The trustees also noted that the reduction in medicare spending reflects continuing efforts to combat fraud and abuse, and that credit goes largely to your Department, Madam Secretary, and you deserve special thanks for your work in this area.

But I think, Mr. Chairman, you would agree have virtually stated, that this good news should not be used as an excuse to delay reforms that will be needed to sustain the program in the future. But the new projections should give us some time to carefully evaluate what works and what doesn't and to phase in change over a longer period of time.

We know that reforming medicare is difficult and complex, and that, not partisan politics was the real reason why the Bipartisan Commission on Medicare was unable to reach a consensus. The truth is there is no surety on how to restrain health care costs over the long run without reducing the quality of care that our elderly now enjoy.

One thing does seem clear. While we need to modernize and reform the program, extending medicare solvency almost certainly will require more resources. And that is why the Democrats want to allocate 15 percent of the projected combined budget surplus for medicare, as we proposed during the debate on the budget resolution. Unfortunately, our friends on the other side have derided that proposal. They argue that reserving a portion of the surplus for medicare won't really help the program because it would only provide the trust fund with meaningless IOUs. I don't believe that is right. The so-called IOUs that the President wants to provide to the Medicare Trust Fund are not meaningless pieces of paper. They are financial instruments backed by the full faith and credit of the United States. They are as real as a dollar or any other financial instrument.

We must keep in mind that the United States has never defaulted on an obligation backed by its full faith and credit—never—and if it ever did, the result could be a worldwide financial catastrophe. So that is not going to happen. So, to describe these as meaningless IOUs I think is misleading at best.

Moreover, the Democrats' plan would not only extend medicare solvency, it would reduce debt held by the public, significantly reduce long-term interest costs, and free up real resources to back up our commitment to medicare. By contrast, the plan that survived is not to save this money but to spend it on tax breaks, as well as other programs. Judging by S. 3, the rate cut championed by the Republican leadership and statements by the chairman of the Finance Committee, those tax breaks will go largely to the wealthiest among us. In any case, they clearly will starve the Treasury of resources that will be needed to support medicare.

Meanwhile, the Republican budget simply ignores medicare. It fails to reserve even one penny of the projected non–Social Security surplus to extend solvency or to make any changes to the provisions in the 1997 budget act. In effect, the Republican plan for medicare calls for provider cuts and higher costs for beneficiaries, and that, in fact, is essentially what the Republican members on the Bipartisan Commission, with one Democrat, proposed. It is essentially what the Senate Republicans endorsed in their budget

resolution. The Breaux-Thomas proposal raises the retirement age, charges additional fees for home health and other services.

More than 3 million Americans between the ages of 55 and 65 are already uninsured, and this proposal would force even more senior citizens to go without health insurance. In addition, the plan's premium support proposal could adversely affect premiums for the traditional Medicare Program.

Without mistake, cuts like these and other deeper cuts are going to be necessary if Republicans succeed in allocating the budget surpluses as they have. And I would also remind my colleagues that many of those surpluses were created in the first place by medicare cuts that have yielded unexpectedly large savings.

We have got to do better than that, and I understand, Secretary Shalala, that you will soon unveil your ideas for making the program solvent over the longer term. I look forward to hearing your ideas on this subject. I look forward to working with you to protect medicare, not only for today's seniors but for all Americans. And so goes the truce between Lautenberg and Domenici that was so nicely fashioned last night.

Chairman DOMENICI. Senator Frist.

OPENING STATEMENT OF SENATOR FRIST

Senator FRIST. I will be very brief out of respect for the Secretary. I appreciate you coming by. I am looking forward to your comments.

Let me just say that I don't want this to be a debate on the Bipartisan Commission on Medicare, but I was and remain sorely disappointed because I believe the President did not engage that Commission. We can talk about what we came up with and why, but I thought it was a great opportunity to come forward. We worked in a bipartisan way on the Commission, but felt that he was not fully engaged and, therefore, we lost a grand opportunity.

To argue about 15 percent of the surplus, which became the mantra in that committee just like it is today, is inexcusable because it translates down to a disservice to seniors, to the younger generation, and sets up this intergenerational battle. I am sorely disappointed that it comes down to—whether it is IOUs, the words we just heard, or whether it is 15 percent surplus—instead of restructuring a program in a way that does reflect the integrity of health care. And I say that in a non-partisan way because we were bipartisan people on that Commission, but I do think that the President did a disservice to the country by early on not telling the Commission what to do and not engaging with an accurate exchange of ideas.

With that, let me stop because I know you have been waiting to speak, and I will have questions afterwards.

Chairman DOMENICI. I thought we were going to proceed, but we have another Senator who has arrived. Some leave, some come. All want to talk.

OPENING STATEMENT OF SENATOR CONRAD

Senator CONRAD. I just want to say welcome to the Secretary. Thank you very much for being here, and we respect the terrific leadership you have provided on this issue and so many other

health issues as Secretary. We very much look forward to your testimony.

Thank you for being here.

Chairman DOMENICI. Madam Secretary, before you speak, I want to talk to the C–SPAN audience that is listening. In case you wonder why I won't answer Senator Lautenberg's speech, first of all, I didn't think that was the subject matter of this morning's meeting. And then if you are regular C–SPAN listeners, you have heard the speech six times on the floor, and you have heard my rebuttal seven times. So I don't choose to do it again today, but I thank you, Senator, for your kind remarks regarding what is going on in medicare, and I will only make one statement.

The Republican plan, if implemented, and if the President will help us by talking about a realistic reform package that can be worked in a bipartisan manner, this budget we produced will provide ample resources to get the job done. The problem is some people want to keep the issue alive and some want to solve the problem.

Now, would you proceed, Madam Secretary.

STATEMENT OF HON. DONNA SHALALA, SECRETARY, DEPARTMENT OF HEALTH AND HUMAN SERVICES

Secretary SHALALA. Thank you very much, Senator. In the interest of time, I have submitted a longer testimony to the committee, and I will read a short version of it, which will take only a few minutes.

Mr. Chairman, Senator Lautenberg, members of the committee, thank you for giving me this opportunity to discuss the future of medicare. As you know, last month the medicare trustees projected that the life of the Medicare Trust Fund has been extended until 2015. That is 7 years longer than projected in last year's report. This certainly affirms that the steps we have taken together in the past are now yielding real dividends. But it also underscores the need for additional action to strengthen and modernize the Medicare Program.

The President is passionately committed to strengthening medicare for the future. Since its enactment in 1965, the promise of medicare has helped to lift and keep generations of Americans out of poverty, while also improving and extending the quality of their lives. During this time, the average life expectancy of our senior citizens has increased from 79 to 82 years. Poverty among the elderly has dropped by nearly two-thirds, and access to health care has increased by one-third.

But when the President took office 6 years ago, the promise of medicare was about to be broken. In fact, the program was projected to go bankrupt this year. Working with Congress, the President supported administrative and legislative changes that, along with a strong economy, have resulted in projected trust fund solvency through 2015. The Administration is gratified by the medicare trustees' recent projection. The Congress should be, too.

But we believe it is a step to build on, not to rest on, because, as the President said last month, we must not be lulled into thinking that nothing more needs to be done. Over the next 35 years,

the size of the medicare population will double from 39 million to 80 million beneficiaries.

As the trustees pointed out, substantially greater changes in income and/or outlays are needed in large part as a result of the impending retirement of the baby-boom generation. Faced with these realities, the President will soon submit a plan that builds on the work of the Bipartisan Commission on the Future of Medicare, and it reflects real changes to modernize the program, including a long-overdue prescription drug benefit.

His plan also will address the central challenge facing medicare, the tremendous influx of new beneficiaries, by proposing that we devote 15 percent of the budget surplus to medicare and so extend the solvency of the trust fund for another decade.

Mr. Chairman, if I might refer to these two charts,[1] the point I want to make here and why putting new revenues into the system is so critical is that the number of beneficiaries will double by 2035, and the medicare beneficiaries will actually grow from 14 percent to 22 percent of the U.S. population.

One-half of long-term real health insurance growth over inflation is attributed to demographics. This is a very important point. Half of the new costs that are coming into medicare are because of demographic changes, not because of changes due to new technology being introduced, not because of changes due to health care costs in general or inflation increases in health care. We have new people coming into the population.

We believe that we need new financing sources, and one of the things that I will demonstrate both in my answers to questions as well as in my presentation is that the Breaux-Thomas plan actually indirectly makes this point. They tried to make all sorts of changes in the program, including shifting costs to beneficiaries and continuing the cuts to the health care industry, but they could not come up with enough money to take care of the demographics that are about to occur. It takes a new infusion of dollars.

The second point I want to make is that medicare is as efficient as the private sector in controlling spending growth. Mr. Chairman, you made the point about the growth of medicare, but if I might make the second point, that is, that medicare has been very good to actually keep its overall spending per capita below that of the private sector. Medicare is in the blue; the private sector is in the sort of dull maroon.

The point here is not that there has been an overall growth of medicare spending, but that medicare has, in fact, tracked the private sector and been a little under the private sector. That means that the program, with the help of a series of bipartisan changes that have taken place over time, has been able to keep its spending growth in check. This is not a justification for not doing more, for not increasing the number of reforms that we think need to be done in the Medicare Program.

I am not arguing that we should simply put new reforms in the system. The President has argued that we need both new reforms as well as new revenues.

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[1] Copy of chart not available.

Before I discuss our plan for the future, I would like to report where we are today. As I stated, based on current projections, the Hospital Insurance Fund should remain solvent until 2015, and that means that in the last 2 years, we have actually extended the life of the trust fund by a full 14 years and cut the 75-year actuarial deficit by two-thirds, by 66 percent.

But the reasons for these improvements are perhaps even more important than the numbers. The trustees and the independent medicare actuary found several factors contributed to the economic good news for medicare:

First, that the robust national economy has helped increase the payroll tax revenue into the trust fund and hold the line on health care cost;

Second, that the Department's rigorous management of the Medicare Trust Fund and our historic attack on waste, fraud, and abuse has returned more than $1.2 billion to the trust fund. In fact, for the first time in history, the trustees are reporting that our efforts at waste, fraud, and abuse and the behavioral changes by the industry itself on things like coding, reducing the amount of upcoding, and reducing the number of errors, are actually having an impact on the bottom line of the trust fund;

And, third, the bipartisan Balanced Budget Act, which is an important legacy of this committee, made important and overdue changes in how medicare pays providers, and our emphasis on prevention benefits and in expanding health plan choices for beneficiaries.

Now, I know that Members of Congress are hearing from a variety of providers about the effects, some of them perhaps unintended, of some of the payment reforms included in the BBA. I will remind this committee again and again, that in order to get that balanced budget, the Congress had to be very prescriptive—that is, more prescriptive than you have ever been with the Medicare Program. The amount of flexibility that was built into those changes was very tiny because the Congress needed to get scoring, and so those changes were extremely prescriptive. And as we talk about those changes and what we can do about them, if we choose to do anything about them, we have to look very carefully at the evidence of what we were trying to do at the time and of the enactment of the Balanced Budget Act.

We must continue to examine the situation to make sure that beneficiaries continue to have access to the care they need, and that we have the administrative action to address the concerns, as is appropriate. At the same time, we have to recognize that changes in the BBA will require cuts in other places or new revenues, and these changes could also adversely affect the progress that we have made in extending the life of the trust fund.

I want to send you a message that I am both open to new information and sensitive to the concerns that medicare beneficiaries have about the quality of their care and about the consequences of the cuts that we made in a bipartisan manner. But I also want to warn you that the Congress was very specific when it laid out those changes.

But thanks to the three factors that I outlined from cuts——

Chairman DOMENICI. Madam Secretary?

Secretary SHALALA. Yes?

Chairman DOMENICI. Could I just say I think that is right, but I don't think that is right on nursing homes.

Secretary SHALALA. I am prepared to answer the question about nursing homes because I will tell you exactly what happened on nursing homes. We have been able to keep the promise of medicare, I believe, for many more years—in this case, 14 years over the last 2 years—for the current generation of older Americans. I would like to turn to the future and discuss the work of the Bipartisan Commission on the Future of Medicare and the President's plan to strengthen and modernize medicare.

First let me say that we appreciate the hard work of Senator Breaux and Congressman Thomas, as well as the thoughtful contributions of the other Commission members, in particular, Senators Gramm and Frist, who are members of this committee.

While there wasn't a sufficient number of votes to report out a set of recommendations, the Commission's work helped to highlight the challenges that we face and include a number of ideas that are very worthy of consideration.

The Breaux-Thomas proposal which came out of the Commission calls for making the traditional Medicare Program more competitive by adopting many of the management tools that are used by the private sector.

The proposal would rationalize medicare's complicated and confusing cost sharing, and it proposes doing so by eliminating cost sharing for preventive services and in other ways.

Finally, the proposal includes a modest but positive plan to improve drug coverage to low-income medicare beneficiaries. We applaud these ideas, but the proposal also falls short in our judgment in a number of key areas, and, therefore, the President cannot support it.

First and foremost, the proposal does not address medicare's long-term solvency, and it ignores the need for new revenues given the growing number of beneficiaries, the previous point that I made. There are so many new beneficiaries coming into the system that there is nothing that you can do in terms of shifting costs, as Breaux-Thomas demonstrated, that will cover those new beneficiaries. Therefore, the need for the new investments.

Commission staff has estimated——

Chairman DOMENICI. Madam Secretary, fellow Senators, I have to go to the floor, and so I would like to just thank you for coming up here, and from my standpoint, I am sorry we wasted so much time and didn't get to the issues that we thought we were going to talk about.

But I would say to all of you I have asked the health delivery system and all its components to get together in New Mexico and meet and talk about what kind of problems are they having with the implementation of the Balanced Budget Act amendments in the nursing home, medicare, and home health care, and HMO coverage by insurance.

Frankly, the litany of problems that are coming up, especially for rural States, are absolutely incredible. In fact, I do not believe without change that we will in my State—and I predict there will be many more like it. I don't believe we are going to be able to live

with the current set of regulations that HCFA has put forth with reference to hospitals and nursing homes. And, in particular, I would say we happen to be the headquarters for the largest nursing home company in America, and I don't know whether the Department and HCFA dislikes them or whether because they are big they shouldn't exist or they overspent a couple of years. But the truth of the matter is when you base the payments for nursing home on 1995 costs and you do that overnight, obviously they lose a lot of revenue. And, essentially, when you apply that across the board to the services they are delivering, there is a huge cash flow that is no longer happening.

Frankly, we can sit by and do nothing, and it isn't our prerogative to pass the laws. But I am doing it to get anybody's attention, be it committees of Congress or whomever, that we have to have some changes in some of the regulations and some law changes to alleviate some of these problems, or we are just not going to have rural health as we currently think of it. And we are not going to have as many seniors under medicare who are going the optional route that you have spoken so often of. I think they are going to get out. And they are not getting out because fee-for-service is great. It is because this program is—the way it is structured, it doesn't do justice to them. I mean, there is no use for them to be in it. It is worse in it than getting prescription drugs or some other advantage that they are given.

I would just lay one question, since we are rehashing who did what when and whose plan is good, the best for whom. I just would like you to answer one question so that everybody listening will have your answer, too.

The President in his budget, the President in his State of the Union Address, did not provide any money for prescription drugs. Yes or no?

Secretary SHALALA. He did not, and he will——

Chairman DOMENICI. Thank you.

Secretary SHALALA. We will provide the offsets or whatever the revenue sources are in our recommendations to the Congress, and we understand that the prescription drug benefit has to be paid for. The Commission struggled with how to pay for the prescription drug benefit, but the President will not send to Congress any recommendation that does not have appropriate offsets or does not have a source of revenue that he had identified. That is the role of the President when he sends up recommendations to the Congress.

Chairman DOMENICI. And the 15 percent that is put in the IOU-type fund does not pay for any of these programs?

Secretary SHALALA. Senator, we can debate what our alternatives are——

Chairman DOMENICI. I am just asking. Does it?

Secretary SHALALA. The point that I am making here is that we can't get there unless we are prepared to spend new revenues, and the President has identified a revenue source, that 15 percent, along with reforms in the Medicare Program. I never want to say increase the revenues—or identify the revenues without simultaneously talking about the reforms in medicare that we think ought to take place.

Chairman DOMENICI. Would the Senators permit me to just have her answer the nursing care before her statement is finished? I will listen to that, and then I will turn it over to Senator Frist.

On nursing homes, you have heard my generalized opinion and view. Could you tell us what is going on in nursing care?

Secretary SHALALA. Yes; I will tell you exactly what is going on.

Through the Balanced Budget Act, we were told to make changes to the payment system of nursing care. We did not have updated information. We were given a date to get the system in place, which means that we had to use the data that we had. The industry agrees that we do not have updated data. We will have updated data. They will provide it by next year, and we will put a new payment system in place.

But as I said before, Senator, we were put in a very prescriptive situation—this was not an optional decision—our course was prescribed for us. This is exemplified by the fine-tuning or changes or reviews that we need to make in the home health care. As you know, I sent a team to New Mexico to take a look at home health care. The GAO has reviewed the reductions in home health care to look specifically at access issues. And the same thing with the hospitals, with the academic health centers, wherever the Congress put in place new payment systems, we have stuck to the letter of the law, identifying for Congress where we thought there was problems.

The industry and the Department agree on the need for additional data in the case of nursing homes. I have heard no challenge to the fact that we can substitute something that we don't have or that we can disobey the law. But we are clearly open to having accurate data, to making sure the time frames are appropriate, and to getting the flexibility so that we can work through this transition.

Chairman DOMENICI. Fellow Senators, let me just suggest—and I will predict this for all of you and for the Secretary—if we wait until next year to update the cost reimbursement for nursing homes, we will lose a huge percentage of them to bankruptcy across this land. And there is no question about it.

Now, how do I know that? The Department knows that. They have sent out circulars to the States, to the sovereign States, saying, Are you ready for the bankruptcy of nursing home facilities in your States? Do you have an emergency plan? Do you have some way to get resources to pick up the slack?

Now, why in the world would we sit around and watch an industry go bankrupt, waiting around for next year's information? We need some help now, and, frankly, Dr. Shalala, we do not believe your hands are tied. We believe you can change the regulations yourselves, and it is not rigidly built in by the BBA.

Secretary SHALALA. Senator——

Chairman DOMENICI. Now, you don't have to do it, and we may never do it. But I know what is going to happen, and everybody here that has talked to nursing——

Secretary SHALALA. Senator Domenici, let me make the point again. The base year for both the skilled nursing facilities and for home health care, the year that we were to use was written into law.

Now, I share everybody's concern about the impact of these changes, but I think it is important to recognize that a lot of detail was written into law as part of the balanced budget being enacted quite quickly. And your earlier point, unintended consequences, too quick of changes, using old data, are issues that I accept. But we, Congress and the Administration, did it together, and we ought to fix it together if there are serious problems here and if there are access problems for beneficiaries.

But my point is that this was a very prescriptive law, or you would have not gotten the——

Chairman DOMENICI. Madam Secretary, let me just say, the year is set on nursing homes. But there are many other regulatory aspects to how you reimburse nursing homes that are subject to a great deal of discretion. I would merely ask that you recognize that it is a serious problem. If you don't believe it today, go ask and you will find that it is an enormously big problem. And then we cooperate together to try to get something done.

Secretary SHALALA. I think there are problems there that we ought to cooperate, but let me say this to you: We need to tell you if we need legislative changes. The Department has never been reluctant to use—in fact, we have been criticized for using the flexibility that is available in law. And there has never been an indication under my leadership that we haven't taken advantage of every inch of flexibility that we have been given under the law.

So if I say to you, Senator, that this law was prescriptive, it was specific, that the industry and we agree on the inappropriateness of old data and that we need new data, we are not having a real disagreement here.

Chairman DOMENICI. All right. Thank you.

Secretary SHALALA. But we have to make sure that what we do next is accurate.

Chairman DOMENICI. And please understand, my apologies for not being able to stay.

Secretary SHALALA. I appreciate that.

Chairman DOMENICI. Thank you, Senator.

Senator Frist, thank you for as long as you can preside.

Senator FRIST [presiding]. Thank you, Mr. Chairman.

Let me—oh, Secretary Shalala, do you——

Secretary SHALALA. I have three more pages if I might finish my statement before we start.

The Commission staff has estimated that the Breaux-Thomas proposal will produce a net medicare savings of $102 billion over 10 years. That is less than a third of the savings that is assumed under the BBA. More than $35 billion of the savings would come from shifting the cost of medicare direct medical education to other areas of the budget. The plan derives a substantial portion of its savings by increasing costs for beneficiaries, which is an issue for rural areas as well as for beneficiaries in terms of their choice.

Under the name of competition, the centerpiece of the proposal, premium support, also derives a substantial portion of its savings by shifting costs to beneficiaries. The independent medicare actuary estimated that under the Breaux-Thomas proposal, traditional fee-for-service premiums could rise by as much as 18 to 30 percent. We are concerned about the potential effect of this plan on rural

areas. The Breaux-Thomas proposal would protect against fee-for-service premium hikes for beneficiaries who live in an area where no medicare managed care is offered, North Dakota, for example. But if one private plan comes into North Dakota and that plan does not include an individual's physician, the individual would have to pay a much higher premium to stay in the traditional program and to keep their physician.

For the first time in the history of medicare, medicare beneficiaries in different counties could pay substantially different amounts for the same fee-for-service benefit package. The plan does include a prescription drug benefit, but because it is administered as a means-tested benefit, nearly 60 percent of medicare beneficiaries who don't have any drug coverage would not qualify.

In light of his concerns with Breaux-Thomas, the President has pledged to generate his own recommendations to strengthen and modernize the Medicare Program. We are committed to working with Congress. We intend to build on the Breaux-Thomas proposal to develop and pass a plan that keeps the promise of medicare for the next century.

Specifically, we are working to develop a plan that conforms to the following principles:

The first one is that we must make the program more efficient and competitive. To do this, we believe that medicare should be allowed to use the same effective practices that private health insurers use to constrain costs. We also are examining options to reduce fraud, to constrain costs, and to make payments more competitive and efficient.

Our second principle is to ensure that medicare's guarantee of benefits is strong and includes a long overdue prescription drug benefit. Nearly all beneficiaries use prescription drugs, and the cost is three times as high as that paid by other adults. But less than 25 percent of beneficiaries have private retiree or Medigap coverage, and the numbers are actually declining in the number of medicare beneficiaries that come in and are able to get a prescription drug benefit.

Our third principle is that we must put medicare on sound financial footing by dedicating 15 percent of the budget surplus to the program for the next 15 years. This infusion of much needed revenues would extend the HI Trust Fund for another decade. The plan does not create an unlimited tap on general revenues. It invests a fixed portion of the surplus in medicare to cover the temporary but overwhelming influx of retirees—the point I made earlier.

Mr. Chairman, members of the committee, by working together we have kept our promise of high-quality, affordable health care to the 39 million current beneficiaries in the Medicare Program. But as the baby boom becomes the senior boom, we still face a daunting challenge. Despite our progress, the Medicare Program must be strengthened, it must be modernized, and it must be put on a strong financial footing. If we want to address the needs of future generations of senior citizens, we must do this. We must both modernize the program, we must reform the program, and we must make a commitment to put new money into the program. The President and his Administration are committed to working with Congress and with this committee to do just that.

I would be happy to answer any questions you have, Senator Frist.

Senator FRIST. Thank you, Madam Secretary, and as always, appreciate your superb presentation and do appreciate all that you do in so many ways for our health care system and other fields as well.

[The prepared statement of Secretary Shalala follows]:

PREPARED STATEMENT OF HON. DONNA E. SHALALA, SECRETARY, DEPARTMENT OF HEALTH AND HUMAN SERVICES

Chairman Domenici, Senator Lautenberg, distinguished members of the committee, I appreciate having the opportunity to appear before you today to discuss the future of medicare. As you know, the medicare trustees projected last month that the life of the Medicare Trust Fund has been extended until 2015—7 years longer than projected in last year's report. This report affirms that the steps we have taken together in the past are paying real dividends. But it also underscores the need for additional action to strengthen and modernize the program for the future.

As we near the end of the 20th century, we can all point with great pride to the legacy of the Medicare Program. Since its enactment in 1965, medicare has helped to lift and keep a generation of Americans out of poverty while improving and extending the quality of their lives. During this time, the average life expectancy of our senior citizens has increased by 3 years, from 79 to 82 years. Poverty among the elderly has dropped by nearly two-thirds. And access to care has increased by one-third.

Before medicare was enacted, more than half of our senior citizens were uninsured at a time in their lives when their need for health care was the greatest. Today, virtually every American over the age of 65, and millions of other Americans who have disabilities, live with the security of knowing that medicare is there for them if and when they need it. This peace of mind also is vitally important to millions and millions of working men and women in this country who worry about the well-being of their parents and their grandparents.

President Clinton has a passionate commitment to strengthening medicare for the future. When he took office 6 years ago, medicare was actually projected to go bankrupt by this year. Working with the Congress, he has supported administrative and legislative changes that, along with a strong economy, have resulted in projected trust fund solvency through 2015. The Administration is gratified by the medicare trustees' recent projection. The Congress should be too.

But as the President said last month, we should not be lulled into thinking that nothing more needs to be done. Over the next 35 years, the size of the medicare population will double from 39 million to 80 million beneficiaries. While the emergence of new technologies will improve the quality of care, they also may be costly. The Trustees' Report points out that "substantially greater changes in income and/or outlays are needed, in large part as a result of the impending retirement of the baby boom generation."

The President will submit a plan soon that builds on the work of the Bipartisan Commission on the Future of Medicare and includes real changes to modernize the program and provide a long overdue prescription drug benefit. And it also will offer an historic opportunity to begin to address the central challenge facing medicare—a tremendous influx of new beneficiaries—through our proposal to devote 15 percent of the budget surplus to extend the solvency of the trust fund for another decade.

Mr. Chairman, before I discuss our plans for the future, allow me to report on where we are today. In our latest report, the trustees projected that the Medicare HI Trust Fund spent an estimated $135.8 billion in 1998 and received $140.5 billion in income from payroll taxes and interest income. This is the first time since 1994 that income to the trust fund exceeded expenses. At the end of 1998, the trust fund's total assets had increased from $115.6 billion to $120.4 billion.

At the same time, the Supplemental Medical Insurance Trust Fund spent $77.6 billion in 1998, while it received $87.7 billion in income for a net increase of $10.1 billion in assets. Total assets in the SMI Trust Fund at the end of 1998 were $46.2 billion.

These figures represent a substantial improvement from 1997 and, based on current projections, they indicate that the Hospital Insurance Trust Fund should remain solvent until 2015. Taking the last two annual reports together, we have extended the life of the HI Trust Fund by a full 14 years and cut the 75 year actuarial deficit by 66 percent.

The reasons for this improvement are perhaps more important than the numbers. The trustees and the medicare actuaries found several factors contributed to the economic good news for medicare.

First, the robust national economy with its combination of low unemployment and low inflation has helped to increase payroll tax revenue into the trust fund and hold the line on health care costs.

Second, the Department's rigorous management of the Medicare Trust Fund and our historic attack on waste, fraud and abuse in the Medicare Program have yielded some remarkable results. Over the last 2 years alone, our efforts to halt these practices have returned more than $1.2 billion to the Medicare Trust Fund. This is the first time in the history of the program that an Administration's efforts to end waste, fraud and abuse have been identified as having a positive impact on the life of the trust fund. I'd like to single out the Health Care Financing Administration (HCFA) for special praise in this area, along with the HHS Office of the Inspector General and the Department of Justice.

Third, but by no means last, is the Bipartisan Balanced Budget Act, which is an important legacy of this committee and the Chairman and ranking member in particular. The BBA made some very important and overdue changes in the way medicare pays doctors, hospitals, nursing homes, home health agencies, and other health care providers. As members of this committee know, medicare is the single largest purchaser of health care services in the United States. The way in which we pay for care often influences the entire health care system. The BBA also mandated the development of new payment systems for home health care, skilled nursing facility care, rehabilitation services, and outpatient hospital services. These new systems, while challenging to develop, will help to make medicare a more prudent purchaser of health care services.

While we modernized our payment systems, we also modernized the medicare benefit package to include important new prevention services, including annual screening mammograms for women over 40, prostate cancer screening, colorectal cancer screening and diabetes management. These changes made medicare more like the benefit packages offered to working-age Americans. In the long run, these new benefits also will help to reduce medicare spending growth by keeping beneficiaries healthier.

While the BBA played a vital role in strengthening HI solvency, it also created a major challenge for the HCFA and all of HHS. When I asked Nancy Ann Min DeParle to take the HCFA helm just after the BBA was enacted, I told her it was one of the most difficult jobs in Washington. Thanks to the BBA, that was an understatement. Working under extraordinary conditions, the men and women of HCFA have done a remarkable job of managing the implementation of this important law.

BBA implementation has been one of HHS' top priorities for the past 2 years. The BBA included 335 provisions affecting HCFA programs and HCFA has already fully implemented more than half of them. Many more provisions are partially implemented and are on track for full implementation according to the timetable laid out by the Act. In the last year, HCFA has published 92 regulations and Federal Register notices, including those to expand medicare's benefit package for diabetes management, bone density measurement, colon cancer screening, pap smears, pelvic exams, mammograms, and clinical breast exams. I am especially proud of our work in this area.

In the area of payment system reforms, HCFA has issued regulations modifying inpatient hospital payment rules, established a prospective payment system for skilled nursing facilities, refined the physician payment system, and begun work on prospective payment systems for home health care, outpatient hospital services, and rehabilitation hospitals.

We have also begun to implement a very important test of market forces to help control medicare costs for durable medical equipment.

I should remind the committee that the agency accomplished this Herculean task at the same time it tackled some of the most difficult year 2000 computer challenges in the Federal Government.

The BBA also expanded the options available to beneficiaries who choose to obtain benefits through a private health plan. New options include preferred provider organizations or PPOs, provider-sponsored organizations or PSOs, medical savings accounts or MSAs, and private fee-for-service plans. HCFA has issued regulations establishing the new Medicare-Plus-Choice Program and is working with health plans and others to help them offer their products to medicare beneficiaries.

HCFA also has recently taken several steps to address some of the concerns raised by plans and others with the initial BBA regulations. Final rules issued in February will make Medicare-Plus-Choice more flexible for plans and beneficiaries. And just this month, HCFA announced plans to move the deadline for plans' sub-

mission of their adjusted community rate applications to July 1. This will help plans by giving them more time to establish their rates. The President's fiscal year 2000 budget also announced several proposals intended to protect beneficiaries whose Medicare-Plus-Choice plans may have terminated or may have reduced their service areas. These proposals would permit certain beneficiaries the opportunity to enroll in Medigap and also would expand the Medigap options to which these specified enrollees may have access.

Mr. Chairman, we are very committed to successful implementation of Medicare-Plus-Choice. Since the Clinton administration took office, enrollment in managed care has tripled to 6.8 million seniors. An important element of this program is beneficiary education. HCFA has launched a multi-pronged national education campaign designed to assure that beneficiaries make choices based on good, solid, unbiased information. We have developed a new medicare handbook entitled "Medicare and You," that was tested last year in five States. We now have a national toll-free call center to answer questions and provide additional information. We have designed a consumer-friendly Internet site *www.medicare.gov* that includes comparative information about health plans being offered in each community. We have enhanced beneficiary outreach and counseling at the State Health Information Assistance Programs. And we participated in more than 1,000 State and local outreach events around the country in senior centers, town halls, and radio call-in shows.

Our decision to test these materials and processes in a small number of States last year has proven to be a very wise move. Despite the complications created by health plan decisions to withdraw from some medicare markets, these tests have given us valuable information that will make our 1999 efforts even more successful.

Mr. Chairman, we know that Members of Congress are hearing from a variety of providers in their States and districts about the effects of some of the payment reforms included in BBA. Ms. DeParle and I have received literally thousands of letters, and have discussed these issues at great length with Members of Congress, providers and their trade association representatives. Through administrative actions, we will continue to address these concerns where appropriate and to make sure that beneficiaries continue to have access to the care they need. At the same time, we must recognize that changes in the BBA would require offsetting cuts elsewhere or new revenues. These changes also could adversely affect the progress we have made together in extending the life of the trust fund. As we continue to monitor the effects of BBA, we look forward to working in a bipartisan fashion to ensure that medicare beneficiaries continue to receive quality health care services.

Now, I would like to turn to the future and discuss both the work of the Bipartisan Commission on the Future of Medicare and the President's plan to strengthen and modernize the program.

First, let me say that we appreciate the hard work of Senator Breaux and Congressman Thomas, as well as the thoughtful contributions of the other Commission members. In particular, I want to recognize Senators Gramm and Frist, with whom I consult often on a broad range of health care issues. While there was not a sufficient number of votes to report out a set of recommendations, the Commission's work helped to highlight the challenges that we face as we move forward to address medicare's future. The Breaux-Thomas proposal has advanced the debate about medicare in important ways and recommends a number of ideas worthy of consideration.

The proposal calls for making the traditional Medicare Program more competitive by adopting many of the competitive management tools that are used in the private sector. Per capita spending growth in medicare has closely tracked growth in the private sector over the years. All of us should be interested in making sure that the traditional program has the tools widely used by the private sector and medicare managed care (or Medicare-Plus-Choice) plans to ensure continued restraint in spending growth, while recognizing that growth in health care spending has historically exceeded growth in GDP.

The Breaux-Thomas proposal also would rationalize medicare's complicated, confusing cost sharing and proposes doing so in important ways such as eliminating cost sharing for preventive services.

The proposal also recognizes the need for expanded coverage of prescription drugs. Using the Medicaid Program, it contains a modest but positive step toward providing drug coverage to low income medicare beneficiaries.

However, the Breaux-Thomas proposal falls short in a number of key areas and therefore, we cannot support it. First and foremost, the proposal does not address medicare's long term solvency and ignores the need for new revenues to finance care for the growing numbers of new beneficiaries. Commission staff estimated that the plan would produce net medicare savings of only $102 billion over 10 years, less than one third of the savings assumed under the BBA. And, according to Commis-

sion staff, more than $35 billion of those medicare savings would come from shifting the cost of Medicare Direct Medical Education to other areas of the budget. The lack of financing in the Breaux-Thomas proposal would make medicare's financial problems much harder to solve in the future.

Second, the plan derives a substantial portion of its savings from increasing costs for medicare beneficiaries. For example, the proposals to raise the eligibility age from 65 to 67 and to impose unlimited per visit home health copays achieve significant savings in the Breaux-Thomas plan. The proposal to raise the eligibility age includes no workable policy to prevent an increase in the number of uninsured Americans among this vulnerable population.

Under the name of "competition," the centerpiece of the Breaux-Thomas proposal—premium support—also derives a substantial portion of its savings from shifting costs to beneficiaries in the form of higher premiums for traditional medicare relative to current law. The independent medicare actuary estimated that under the Breaux-Thomas proposal that was presented in February, traditional program (fee for service) premiums would rise by 18 to 30 percent, or 10 to 20 percent if Congress enacted the traditional program reforms. Since the Breaux-Thomas premium support design implicitly increases premiums for the traditional fee-for-service program, States paying medicare premiums for low-income beneficiaries also would bear an added cost burden to simply maintain the current level of medicare services.

We also are concerned about the potential effect of this proposal on beneficiaries in rural areas. The Breaux-Thomas plan would protect against fee for service premium hikes for beneficiaries who live in an area with no medicare managed care offering. But if one private plan comes to their area—and that plan does not include their physician—they would have to pay a much higher premium to stay in the traditional program and keep their physician. This approach would lead to an unprecedented situation in which medicare beneficiaries in different counties could pay substantially different amounts for the same fee for service benefit package.

The Breaux-Thomas plan includes a modest prescription drug benefit; however, because it is administered only as a means tested medicaid benefit, nearly 60 percent of medicare beneficiaries without drug coverage would not qualify. And experience with medicare premium assistance programs shows that only about half of people eligible for these medicaid benefits actually enroll.

A final concern with the Breaux-Thomas plan is its call for creation of a new bureaucracy to oversee the premium support program. This board would approve health plan benefit packages and rates, decide on service areas, and enforce financial and quality standards among other activities. Not only is this new bureaucracy unneeded, but it could remove billions of dollars from traditional government oversight and accountability since it is not subject to executive branch rules. This could be particularly problematic in our fight against waste, fraud and abuse.

In light of his concerns with the Breaux-Thomas proposal, the President has pledged to come forward with his own recommendations to strengthen and modernize the Medicare Program. We are committed to working with the Congress to develop and pass a plan this year to strengthen medicare for the next century. We are working to develop a plan that conforms to the principles he outlined in January:

- Make the program more efficient and competitive;
- Maintain and improve medicare's guaranteed benefits, including a prescription drug benefit, and;
- Assure adequate financing by dedicating 15 percent of the surplus to medicare.

To make the traditional program more efficient, we believe that medicare should be allowed to use the same effective practices that private health insurers use to constrain costs, including selective contracting with lower cost, higher quality providers, and competitive bidding for services like medical supplies. We are examining other options to reduce fraud, constrain costs, and make payments more competitive and efficient.

Our proposal also will ensure that medicare's guarantee of benefits is strong. Medicare provides coverage for some of our most vulnerable citizens. We must strengthen the program but not do so at the expense of a clear, defined set of benefits.

One of the President's top priorities is to provide a long overdue prescription drug benefit. Nearly all beneficiaries use prescription drugs and the cost they pay for those drugs is three times as high as that paid by of other adults. Yet less than 25 percent of beneficiaries have private retiree or Medigap coverage and these numbers are declining. Beneficiaries without drug coverage typically pay much higher prices than insurers do—exacerbating the problem.

Finally, the President's proposal will put medicare on sounder financial footing by dedicating 15 percent of the budget surplus to the program for the next 15 years. This infusion of much needed revenues would extend the HI Trust Fund for another decade. The plan does not create an unlimited tap on general revenues, but instead invests a fixed portion of the surplus in medicare to cover the temporary but overwhelming influx of retirees. The surplus was largely created by the baby boom generation and makes sense as a one-time funding source for medicare.

Mr. Chairman, members of the committee, by working together we have made remarkable progress in keeping our promise of high-quality, affordable health care for the 39 million beneficiaries of the Medicare Program today. And we have made important progress toward assuring such access to future beneficiaries. But we still face a difficult challenge. Despite our progress, the Medicare Program must be strengthened, modernized, and put on a strong financial footing to address the needs of future generations of senior citizens. The President and his Administration are committed to working with the Congress to achieve that result.

Mr. Chairman, 34 years ago, our Nation made a promise to some of our most vulnerable citizens. We promised that if they worked hard and saved for their retirement, we would make sure that they have access to the high-quality, affordable care they need to live their later years in security. Our parents and grandparents kept their end of the bargain. Now it is time for us to do the same. I look forward to working with the members of this committee and both houses of Congress to make sure that we keep our word.

I'd be happy to answer any questions. Thank you.

Senator FRIST. I will ask that my opening statement be made a part of the record at this juncture, and I will not go back with a formal opening statement.

[The opening statement of Senator Frist follows:]

OPENING STATEMENT OF SENATOR BILL FRIST

Mr. Chairman, I want to thank you for holding this very important hearing today on a matter that is crucial to our Nation's seniors and individuals with disabilities—medicare.

As we all know, the most significant challenges before Congress over the next few years are the twin interrelated crises of medicare and Social Security. Though we hear a lot about saving Social Security, we don't hear as much about saving medicare which, even with the latest projections, is slated to become insolvent in just over 15 years—well before Social Security is scheduled to go bankrupt in 2034.

The recent Medicare Trustees' Report certainly is good short-term news for medicare but it shouldn't diminish our determination to find a solution that ensures the program's long-term strength. Just as a strong economy can prolong the trust fund's solvency, a sluggish economy can quickly erode it. We should not take this news as an excuse to relax, but instead we should continue working to find a way to strengthen medicare. Although the time frame of medicare's solvency constantly changes, one fact we know for sure is that without structural reform, the program will go bankrupt. Now is the time to work toward both eliminating that constant threat and also improving medicare.

The opportunity to reform is now—while we have adequate time for transition and implementation. The Balanced Budget Act gave us the time to focus on the problem—I have spent the past year as a member of the Bipartisan Medicare Commission reviewing this program, its success, its shortfalls, its future.

Strong economic growth has resulted in more funds flowing into the HI Trust Fund—since there is no longer a cap on the HI payroll tax, the trust fund receives nearly 3 percent of all wages. Indeed, this improves the financial condition of medicare—moving us away from the trend of deficit spending in the program. The more years we can sustain spending without significantly dipping into the reserves, the better off the program is financially. However, the Public Trustees make the point that *". . . we cannot prudently rely on economic growth continuing at this rate."* It's significant to note that even a robust economy fails to sustain the program. The HI Trust Fund is now projected to remain solvent until 2015. Years before, medicare expenditures will exceed all the tax income to the trust fund and increasingly rely on its reserves of annual interest income.

In addition, we must recognize that a strong economy and slower spending growth only get us so far in sustaining medicare. It's painfully obvious by the Trustees' most recent report that the current program cannot address the demographic brick

wall presented by the baby boomers. In fact, the new projection for insolvency is soon after the onset of baby boomers becoming eligible (2010–2030).

Also, there are other factors that require changes to the Medicare Program. The Public Trustees point out that costs increase due to *"new, more expensive (and effective) medical technology"* and *"because an aging U.S. population has greater medical care needs."* When medical science introduces new therapies, medical devices and procedures, we want our parents or grandparents to have the best that medicine offers. But, medicare will need more flexibility in the way care is delivered to accomplish that goal.

I appreciate the comments by the two Public Trustees regarding the fear of change. Like the Public Trustees, I believe we should be reassured that medicare has been adjusted many times since its inception—as has medicine. The Public Trustees stated that *". . . there is no reason for us to think now that Social Security or medicare should be frozen in place for decades ahead."* If we hope to improve the care available to our seniors and individuals with disabilities, we should seek change that will accomplish this in a responsible and honest manner. Solvency is important, but restructuring the delivery system assuring coordination and encouraging innovation and comprehensive care is equally important. Reliance on provider cuts or budgetary gimmicks will not accomplish the improvements that medicare beneficiaries deserve.

I look forward to hearing Secretary Shalala's testimony this morning and to further discussing these issues during the question and answer period. Thank you, Mr. Chairman.

Senator FRIST. Let me jump straight into a couple of questions of the Medicare Commission and the view that the Administration has of that being a blueprint, obviously there being a lot of areas of concern, and those of us working in a real bipartisan way, and I want to share that with you and with others because it was a real bipartisan effort on the committee and working with Democrats, Republicans, and the public members as well as the elected officials. It was really a great experience. I think we learned a great deal. I had felt it was a great blueprint. I didn't agree with lots of things in there. None of us did, nor will we. As long as we all keep our eyes on the goal and act quickly, not too quickly but quickly, because this is a problem we have to address, I believe, now and not 10 years from now.

It is so different than Social Security where many of us are spending a lot of time as well, because anything that we do in health care we all know has the unintended consequences, the repercussions, and those get translated down so directly to not just companies going bankrupt and dollars having to flow and be infused, but to patient care, to that security if you have a heart attack that you will be taken care of in an appropriate, high-quality way.

It comes back to me as a physician that quality today is not what it should be in medicare, and, therefore, that lends a whole other sense of urgency that we all need to focus on as we talk about the year 2015 and 15 percent of the surplus and IOUs, which is what the Budget Committee does. And I guess my two points are that we need to act now because it takes a while. We have seen the infrastructure development, the coordinated care, the networks, having people participate in terms of team approaches, the collection of data which you feel so strongly about, and I agree with, in order to make future decisions. It takes so much time that, unlike just dealing actuarially with the demographics, we are talking about health care, health care systems, delivery, use of technology, and that is the sense of urgency that I feel.

That leads me to something that is a criticism. I don't feel the President wants to solve this problem in the next 2 years, and that is an area of debate, and I know the reply will be we want to. But I just don't sense that, and that bothers me. People recognize that the numbers look better, and the trust fund, for the first time in 5 or 6 years, had a little more coming into the cash drawer than going out, and I can tell you that it makes people relax. It made people on our Commission relax. Maybe we don't have to be moving so aggressively, but from a quality care standpoint, a delivery system standpoint, I believe we have to move in an urgent fashion.

Now, premium support, the model, an FEHBP-type model as a blueprint. As you know, our evaluation by Commission staff, by people from the CBO and I believe the GAO, but collectively, everybody who came in said that a more competitive model like an Federal Employees Health Benefit Plan, which is the premium support, the terms that we used in our Commission, to be that type of blueprint, would slow the growth, whatever it is. Right now the growth is slow, and we feel good about it, though I can tell you when the economy is not as good and when technology continues along, it is going to come back up. There is no question that it will. Premium support, that model will slow the growth by about 1 percent a year, and that is significant when you compound that over 5 years or 10 years and you are starting as a base of a couple hundred billion dollars.

Do you agree with that assessment that a model, more competitive model like premium support, will result in saving—same quality of care, but savings—maybe better quality of care, but savings of 1 percent a year?

Secretary SHALALA. Because we have not seen the legislation, and as you know the independent actuary was only able to evaluate the February draft of the Commission, not the draft that you all voted on because he did not have enough detail. So I cannot answer that question specifically about the model that you submitted.

I can say this to you. That if you look at the proposal, a significant portion of the revenue that was generated in the proposal came from the premium support model. But within the premium support model, the way you got the savings was by shifting costs to beneficiaries. What you did, as you well know, is make fee-for-service more expensive as a way to get people to move into managed care.

Senator FRIST. And you made that statement earlier. I guess looking at the blueprint, things we can agree on——

Secretary SHALALA. We agree with the competitive aspects.

Senator FRIST. Do you think that medicare could be more competitive?

Secretary SHALALA. Absolutely.

Senator FRIST. And that more——

Secretary SHALALA. And whether you use a premium support model or whether you use the kinds of models we have been trying to develop, which you have been so helpful with, and that is you bid out your business and try to get better pricing all the way throughout the system, there is no question.

We have been, from day one, enthusiastic supporters of getting better prices for medicare, of getting competitive pricing, of making

sure we are not paying more than we should. Introducing more competition into the Medicare Program is absolutely a critical part of——

Senator FRIST. Let me just put on the table, because you know what it is going to be; based on the Medicare Commission, when we talked about competition we came back with a majority vote saying premium support is the way to go.

When you talk about competition, the fear is going to be that you are going to give HCFA more muscle under this aura of modernization, saying it is competitive bidding, but in some way allowing HCFA to come in and underbid the entire private sector in this aura of competitive bidding. Saying that is competition and that is Government savings, but in truth driving out the private sector.

Secretary SHALALA. No, in fact we would argue that the package of fee-for-service reforms, the specific fee-for-service reforms that were part of the Commission report are very important for us to look at. That you cannot simply reform the HMO financing process without simultaneously, I think, getting better control of the fee-for-service costs at the same time.

Now let me say this. The shifting of cost to beneficiaries, particularly for those that wish to stay in fee-for-service is a concern for this Administration. The BBA and all of our conversations to date have been that what we want is real choice. We do not want to tilt one way or another. We want to give people real choice. We want to keep a strong fee-for-service system because, frankly, in many parts of the country that is all beneficiaries have. But at the same time we want to make sure that managed care has a fair shot, can use its efficiencies, can get to an integrated system.

As you well know, most of what we have seen with some significant exceptions has been managed costs. I am deeply committed, as is Nancy–Ann Min DeParle to these new integrated systems, to using those systems to get more quality care. And we have to make sure whatever we lay out is fair to managed care and encourages people, to move into these integrated settings as a way of getting more quality care.

We just think that what the Breaux-Thomas plan would end up jamming people into managed care because they would not be able to afford to stay in fee-for-service, which is problematic because the private sector industry has not had a lot of experience with severely disabled people, with people that are much older and much sicker, and that that transition is what we need to talk about. But we think that you can introduce the competition, that you can make an investment in new funds, that you can reform fee-for-service, that you can give managed care a better shot than it is has had up until now, and that all of that can be part of a bipartisan proposal.

Senator FRIST. Thank you. The President will have—at some point before we finish—and I will turn to my colleagues because I know we all have questions. I would like at some point today to have a feel for when we would expect the proposal from the President. Will it be 4 weeks, or 8 weeks or 12 weeks?

Second, is it going to be just a set of principles, or will it really be something that we can work with in terms of maybe not specific legislation but something that really addresses the fundamental is-

sues? Because principles are easy, and we on the Commission started with great principles, and we are struggling with what I am sure all of you are struggling with. But how specific will it be?

Secretary SHALALA. It will be a full proposal, Senator. I have laid out the principles for you of what the elements are going to be. I could not be more sympathetic with the Commission's work. This is hard to do. Obviously what we are talking about is incentives from a competitive system for people to move into managed care because of lower prices and better quality. We would rather do it that way as opposed to running up their fee-for-service costs so that they really have no choice for financial reasons.

We think we can come back to you with a proposal that is a good place for us to start moving a piece of legislation that commits us to competition, commits us to the kind of integrated, organized care that many of us believe is the way to go if we are going to get quality care, and that takes care of the solvency issue. I do not want to talk about reform without dealing with the solvency issue because the President believes that we ought to do the whole thing.

Senator FRIST. We look forward to it. The President, by making the statement essentially put a hold on where we are today, so I think we do need to see that and then we will continue that debate and work for what is best for the American people.

Senator Conrad.

Senator CONRAD. Thank you, Senator Frist. And again, thank you, Secretary Shalala, for being here. I have not had a chance publicly to commend you for your recent daring-do on the streets of Washington where you fought off the muggers and got the license plate, and the perpetrators were arrested. But I want to thank you for making the streets of Washington safer. We have Secretary Shalala, the street hero. So thank you for keeping a cool head. I do not know if many people would have gotten the license plate number in the midst of all that. But you did and it led to the arrests, and that is good news.

First of all, I want to say on the skilled nursing facilities, we really do have a problem here. What you said is exactly right, most of the problem was created by us. Now we all worked together on the Balanced Budget Amendment——

Secretary SHALALA. Us too. I am willing to concede that we did this together, so we ought to figure it out together.

Senator CONRAD. We did do it together. But the fact is it is law. It is not as though you are given a lot of wiggle room here. The problem is, together we passed a law, and that law does set the base year. The base year is 1995. Unfortunately, that is clearly outdated. But that is the data that is available and that is the reason that it was set at that point.

So we collectively need to work at a solution. And one of the things I would ask is, is it possible that you could adopt a different market basket? We have got the current skilled nursing facility market basket. Could you adopt the more—I am told it is more accurate, Bureau of Labor Statistics Producer Price Index for skilled and intermediate care facilities? Would that be something that would help? I throw that out there as one possibility to try to relieve some of the pressure here.

Secretary SHALALA. One of the things we want to do is to look at every option. But the point here is, I think we need accurate, up to date data. We will have that. We are in the process of collecting it with the industry's cooperation. While we are happy to look at any of the individual changes, I think what we want to make sure is that we have regular, accurate data for the payment system.

So I would be happy to look at anything you suggest, but we expect to have this data next year. I want to check the date of it before we take any interim steps. I also think we want to know what the costs are going to be as part of this.

Senator CONRAD. Could you investigate this question and get back to the committee on it?

Secretary SHALALA. Yes.

Senator CONRAD. The second question I would have is, using 1995 as the base year creates disadvantages for certain facilities that increased their involvement after that year. Therefore, the transition to the full Federal rate actually disadvantages some skilled nursing facilities. Would the Administration be willing to allow such facilities to opt directly to the Federal rate?

Secretary SHALALA. I actually do not know the answer to that question but I will get back to you on that question. The question is on the record and I will get an answer back to you.

Senator CONRAD. Let me go to the larger question. Senator Frist, I want to publicly commend him for his involvement in the work of the bipartisan commission. It is not easy. Two days ago, Finance Committee members on a bipartisan basis met in the Library of Congress all morning for a fact-finding on medicare. Where are we? Where are we headed? What are the options?

I will tell you, I do not think anybody left there without feeling, this really is going to be heavy lifting. Because what you pointed out is the central fact. We are going to double the number of beneficiaries. We have got a demographic time bomb out here, the baby boom generation. When they start becoming medicare eligible, the number of people who are qualified for medicare, as you point out, are going to double. And it does not add up.

And frankly, we have got problems now. In a rural area, my State, North Dakota, where you have been and you have family and you know well, we have already got problems. Every single community forum I have held this year there have been representatives of the health care community, rural hospitals, rural doctors, rural nurses with a clear and consistent message. They are telling me, look, this does not add up. We are going to lose our hospital. What are we going to do to get relief, and at the same time deal with the enormous cost crunch coming because of dramatic increase in the number of people medicare eligible? That is the fundamental problem that we face. .

I think it is terribly important that the Administration weighed in with a proposal, and I look forward to it. And again, I want to thank you for the leadership you have already provided.

Let me just close with——

Secretary SHALALA. Senator, if I might just with a quick response. One of the good things the BBA did for rural areas is it really did change the payment formulas, introduce a blend and a

floor. North Dakota, for example, next year will get a 7.4 percent increase; Oregon gets a couple percentages more than that. That will help next year.

Senator CONRAD. Can we get some of Oregon's? [Laughter.]

Secretary SHALALA. You will have to talk to the Senator from Oregon on that. That flexibility I do not have.

Senator CONRAD. Thank you very much.

Senator FRIST. Senator Wyden.

Senator WYDEN. Thank you, Mr. Chairman. This has been very helpful.

I would like to talk in some detail, Madam Secretary, about the prescription drug issue and your thinking on it. I recognize that the Administration's position is still being developed. Senator Conrad is absolutely right, we have some heavy lifting to do here, and Senator Snowe and I are trying very hard to do that heavy lifting so as to get a benefit enacted in this Congress.

The way we come to the debate is it seems to me you and the Democrats are absolutely right in saying this is going to take new revenue. Senator Snowe and I got 54 votes on the floor of the United States Senate for a tobacco tax in order to have a pharmaceutical benefit. So this is an indication that the United States Senate wants to be responsive to your point about generating revenue.

It seems to me a number of my colleagues, a number of my colleagues on the other side of the aisle are absolutely right in terms of saying that when you get the extra revenue, you have got to be able to spend it efficiently. You have got to make sure that you squeeze every single dollar out of the revenue you have raised in order to serve the low income elderly.

So I would like to talk to you first about the kind of delivery system that would maximize the benefit for seniors and allow us to go forward and do the heavy lifting that Senator Conrad is talking about in this session.

It seems to me, and I want to catch your attention on this point specifically, Madam Secretary. It seems to me that the delivery system that we ought to use for that pharmaceutical benefit for seniors is the kind of thing that works for Members of the United States Senate and their families. Members of the United States Senate—and I have got a 15-year-old and a 10-year-old who use a lot of prescriptions, they get good value because they get it through the Federal Employee Health System.

I guess my question to you is—and this is what Senator Snowe and I are working through in putting our proposal together is, do you see any problems that you can identify for us in using the system that works for Senators and their families as the delivery system for making sure that older folks get that benefit and we are really using the money we have raised to help them with these huge costs?

Secretary SHALALA. Let me say that in general your leadership on prescription drugs I think has been very important and I want to make sure that I make that very clear and very public. I am particularly interested in your thinking on this issue because we are in the middle of our discussions.

In general, when people have said to me, why not use the Federal workers' system I have suggested that Federal workers are actually a different group of people. They are not sick. They are not old. They have incomes that are going up. It is almost like comparing apples and oranges.

As for using the delivery system as such, it is one of the things we are clearly going to look at. And there are other models within HMOs about how you ought to deliver prescription drug benefit. And I do not need to tell any of you about the importance of prescription drug benefits. In rural America, only 50 percent of the people get any kind of a prescription drug benefit. I mean, it is absolutely critical.

So whether we can take a model that is used for healthier people who have growing incomes and transfer that into the Medicare System, we certainly are going to look at that. But I cannot sign off or suggest to you that that is going to be the model. It is very expensive, as you can imagine.

I would love to talk to my actuary and say, Senator Wyden says that you ought to estimate the cost of this based on the Federal employees model. And he will look at me and smile and point out that these are older, sicker people, and it is going to be a different kind of cost structure that we end up with.

But let me say, we will certainly look at that model. That is one of the models. There has been some private sector experience with delivery systems. There is certainly some HMO experience with delivery systems. We are looking at what would be the most efficient system.

The one thing we have learned in medicare is every time the Government puts money out there, if it is there, everybody is going to run to it. So we want to be extremely careful, including looking at phased-in, to make sure we have got cost controls and great efficiencies built in as we put our foot in the water and start moving toward a benefit.

The other thing that we are very anxious to do is not to income test it. That is, this is a benefit that has got to be integral to the medicare benefit package. The health care system now and the health care leaders are telling us that drugs are going to be absolutely essential to future health care. It is not going to just be technology. It is increasingly the substitute for hospitalization, for outpatient care. Therefore, we ought to see it as a full-fledged benefit, even if we phase it in, or have copayments or whatever, as part of the package.

Senator WYDEN. Let me explore this a little further. First the delivery system and then the eligibility issue. We would like you to furnish for the record any thoughts you have on using the Federal employee model. Senator Snowe and I do not dispute for a second that the populations are different in terms of medicare and Federal employees. What we like is the fact that with the Federal Employee System you have some real competition, you have choice, and it looks like you could give seniors the bargaining power that an HMO has.

I can tell you, right now in Oregon, in Coos Bay, Oregon or Eugene, Oregon, our seniors are getting fleeced because when they

walk into a drug store they pay a premium because they do not have the bargaining power an HMO does.

Secretary SHALALA. Senator, are we talking about the pharmaceutical benefit or are we talking about——

Senator WYDEN. We are talking about strictly the pharmaceutical benefit and how we set up a delivery system. It is our view that the delivery system that works for Members of Congress and their families sure has a lot of appeal in terms of competition and choice. We would like your views on that.

Secretary SHALALA. We absolutely will look at it, and are looking at it, in fact, as one of the options.

Senator WYDEN. Good. Second point, with respect to your views with respect to eligibility. My background goes back, for 7 years I was co-director of the Gray Panthers. We have been through a lot of this discussion.

How do you make sure that you target your resources so that Lee Iacocca does not get the same pharmaceutical benefit with tax subsidy dollars that a woman who makes $17,000 and lives in Oregon or Maine and has early Alzheimer's and a big prescription drug bill has?

Secretary SHALALA. Lee Iacocca actually has a prescription drug benefit, even if he is over 65, because he probably got it as part of his business. And that has always been the great challenge of pharmaceutical benefits. That is, how do you let people wrap-around what they have got without totally substituting Government money for something that someone got as part of the benefit package? As you can imagine, the unions are extremely interested in how we are going to try to do that.

Again, we are exploring ideas. But it is not something that is new for us. As you well know, most Federal retirees do not even take Part B. They substitute their Federal employee's benefit for Part B. They just take Part A.

So how this is structured so that we do not subsidize where we do not need to subsidize, I cannot give you the answer. But that is one of the great challenges of structuring a pharmaceutical benefit. There are people that now have a pharmaceutical benefit. There are people that have lousy Medigap pharmaceutical benefits. And what we want to do is to make sure that everybody in medicare has a decent pharmaceutical benefit without trying to substitute for what exists there, and it is an enormous challenge to try to do that.

It is much easier simply to extend medicaid to 135 percent, which is a solid proposal, but it does not get to large numbers of people, millions of people who have income over 200 percent of poverty.

Senator WYDEN. Mr. Chairman, can I ask one additional question?

Senator FRIST. Absolutely.

Senator WYDEN. On this point with respect to the managed care situation and reimbursement, Madam Secretary. We lost 400,000 people from plans. A lot of them did not have any other options last year. We have a couple of months to go and nobody really knows yet how the sign-up is going to fare then. At what point are you going to say, we have got a crisis here and take action?

For example, one proposal that could be put in place, if hundreds of thousands of more people lose coverage, is changes could be made in this risk adjustment system so as to give plans additional time.

Could you tell us a bit about your thinking in terms of how you are going to approach it? And how many more people are we going to have to lose before we take action, and what is likely to be the action should that happen?

Secretary SHALALA. Let us talk a little about who lost their coverage. About 40,000 people were left with no other Medicare Choice plans when the plans pulled out. About two-thirds of those were in Utah where the health plans told us in June that they were not renewing. The Medicare-Plus-Choice plans—interestingly enough, since you mentioned the FEHBP—the withdrawals by managed care paralleled what happened in the Federal plan. So this was not unique to medicare, or necessarily the Medicare Payment System.

One of the things I just pointed out to you is that the blend will help. The fact that we are increasing reimbursement rates in Oregon and in many of the other States that were affected by the pull-outs will clearly help.

I have also said publicly that when you deal with private sector companies you have to expect a certain amount of withdrawals—if they do not get a good enough foothold in that community. That is, if they are the third managed care plan, for example, and they do not have a large enough population to justify their overhead. If they do not think the payment rates are strong enough, companies are going to have—we have got to expect a certain amount of companies coming in and out of the system. So I think both the impact of the blend next year will help us to keep managed care plans in the system.

In addition to that, HCFA has already taken several steps. The final rules that we issued in February make Medicare-Plus-Choice more flexible for the plans. We have already announced our plan to delay the date on which the plans have to file their rates. One of the things they argued is if they had more time and could make adjustments in their bidding, they would have been able to stay in. We are going to take them up on that and actually give them more time.

The budget also expands the Medigap enrollment options for seniors who lose their plan to give them some kind of protection.

In other words, by the changes that we made in the BBA, by the flexibility that we have offered to the plans, we think that we have addressed some of the objections.

But let me say this to you, as we move to work with private companies, as we expand the number of medicare beneficiaries that are getting managed care, we have to expect that these companies are going to make business decisions on whether they are going to stay in an area or leave an area. Sometimes it will be whether they get enough of a foothold. Sometimes it will be their costs. Sometimes it will be other kinds of factors.

So those of us that are used to the kind of steadiness of knowing precisely what the plan is, better get used to businesses making business decisions about whether they are going to stay in or leave.

Senator FRIST. Madam Secretary, I wanted to actually cut you off here shortly or summarize real quickly, because we are going to vote in a couple of minutes and I want to be able to go to a couple questions.

Secretary SHALALA. OK. But I think my fundamental point is that providers are going to argue that because the BBA cut back so much: we took out the academic health center money, we did risk adjustment which meant that some of them dropped because they had healthier people in their areas. They are going to argue, because of that they are going to have a harder time.

They are going to have to make their case to you, but I think there are some things, some positive things, but I also think we had better get used to this.

Senator FRIST. Madam Secretary, when will we be hearing from the President, roughly?

Secretary SHALALA. The President has said to us—we are working very hard now—that he wants a proposal, a full proposal up here in time for you to pass it before the end of the year, or for us to negotiate with the Congress in a bipartisan manner so that we can get these reforms plus the new investment of revenues in place and finished by the end of the year.

Senator FRIST. Do you think it will be 3 months?

Secretary SHALALA. I do not—I cannot predict that.

Senator FRIST. Cannot be more specific.

Secretary SHALALA. We will just get it up here in plenty of time so that we can have both the conversation and the debate.

Senator FRIST. The President's budget, 2000 year budget, proposed a $9 billion reduction to hospitals, and you had mentioned that medicare spending has substantially slowed. You mentioned also the unintended consequences of the BBA which we all were part of.

Secretary SHALALA. I think I said perhaps. I mean, we are still looking at the cases in these situations.

Senator FRIST. Then also we know that the BBA, what we did pass is still having its effect and the impact is being felt on an ongoing basis.

Secretary SHALALA. Right.

Senator FRIST. We do not know what the full impact is to providers, to facilities, to physicians, to really the health provider community.

What role will provider payment reductions play in any proposal advanced by the White House as we address this longer financial condition of medicare? The provider component of it, when you look at that pie chart, is so big that they feel very strongly, and looking at the President's budget for this year, that all they can look forward to is further tightening, which is driving physicians to no longer be physicians.

People who I have trained with come in every day—not just Government. Managed care is creating this same problem. But they are leaving the field. I do not want to overstate that, but every day I talk to somebody who says, I am getting out of this business because Government is not paying me enough to stay in business, to support my family, and I am just leaving. There are too many other things in life to do.

That is tough to answer because we are in a situation with what the BBA has done. I want to throw the question out, is it going to be more of the same? Is it going to be more tightening that physicians, facilities can expect in the future to the point that solvency is a question for them?

Secretary SHALALA. As you pointed out before, a large proportion of the savings in the Breaux-Thomas proposal were actually continuing the BBA into the outyears. So that obviously was——

Senator FRIST. It was actually worded that either that or similar savings elsewhere. You are correct, but there was a lot of debate in the commission. So that was not in stone.

Secretary SHALALA. Right, but basically we are talking about providers, because you certainly did not intend to suggest there was an option to shift more to the beneficiaries and that is why you went to continuing the BBA cuts.

Part of the recommendations that we made are about $2.3 billion, I think, that the inspector general has recommended that they are in fact related to our anti-waste, anti-fraud proposals. So I certainly want to separate that out from some of the hospital payment adjustments.

We based those adjustments on the data, again, that we had at the time. And we have a fiduciary responsibility, looking at the margins that the BBA based their own understanding on, to come back to you with further recommendations, and that is what we did.

Now the hospital industry has argued very articulately, though obviously both the Congress and the Administration need to look at the data very carefully, that those margins no longer exist. That what we based our analysis on when they did exist, that situation has changed.

Senator FRIST. That 1996 inpatient data mainly.

Secretary SHALALA. And I think we fulfilled our fiduciary responsibility. We did it based on when we had to make the recommendations. We will certainly—if your point is, should we review this? Should we add another set? We should always make adjustment in the payments if we think that is appropriate, given what our expectations are and what we think is an appropriate payment.

As for those in the health care industry that argue that Government is not keeping up its end, I would only point out in the point about controlling spending that the private sector has been just as tough in terms of negotiating deep discounts. I think, as you and I have discussed, one of the problems here is that after the private sector did that, Government did not do very much for a long time. We were very good payers in the system for a very long time.

When we started to pay more accurately, that compounded the problem for the providers. So it is not just us, it is the entirely health care industry getting tighter in terms of what they are willing to pay for.

Senator FRIST. I will close and turn to Senator Snowe. But I guess what concerns me a little bit is even in our exchange now, of whether you continue BBA or not into the future, and you pointing out that the Commission said you may have to do that or find similar savings, or in some way throw 15 percent of the surplus in,

just throw more money at the system. And I understand that you want to reform the system at the same time.

Secretary SHALALA. And we are not suggesting that the surplus be spent on that as opposed to covering these new people coming into the system, which is our point about the surplus.

Senator FRIST. That is correct and I understand. But there really is another dimension there and it goes back to whether it is an FEHBP model or a premium support model or a reform of the system. Not just tinkering and modernizing HCFA, and not just reforming a little bit here and there, because I do not think it addresses the issues that need to be addressed.

But it is not just throwing more money at a trust fund or cutting providers, physicians, hospitals, or just squeezing down more and more, which we have done. But we have done it to the point that people—we are going to hurt people in terms of quality. Whether it is institutions closing. Whether it is home health getting out. Whether it is physicians leaving the field.

There is another option. And that is reform of the system, the way we deliver care. More efficiency, more value, competition—we can debate what that competition is—premium support type model, that that has the potential for introducing, not just throwing more money at it and not just cutting people more. And that potential is what at least the Commission, the majority of people on the Commission were excited about. I hope that we can continue to look at that issue, and President does, and you do.

My final statement is, we very much enjoy working with HCFA. Nancy-Ann Min DeParle has done a superb job. The responsiveness of you and the responsiveness of her in running that organization has, for us, been tremendous as we work towards these solutions.

Secretary SHALALA. Thank you.

Senator FRIST. I know we have a vote that just started.

Senator SNOWE. May I raise one issue?

Senator FRIST. Yes; I want to turn to Senator Snowe and will ask you to use the remainder of the time.

Senator SNOWE. Thank you, Mr. Chairman, and welcome, Secretary Shalala. I know that Senator Wyden already raised the prescription drug issue, so I will not get into that.

Secretary SHALALA. I complimented both of you already.

Senator SNOWE. Thank you, I appreciate that. Medicare prescription drug coverage is a critical issue that we should address this year.

I guess the issue that I would like to get into very quickly is home health care. I am hearing a lot of complaints and concerns from my agencies in Maine as a result of the changes that occurred in the Balanced Budget Act, especially concerning the implementation of regulations and the restrictions these regulations impose on agencies. I know that nationwide more than 2,000 agencies have closed since the passage of the Balanced Budget Act.

I am wondering if there is anything that your department can do, that HCFA can do to address some of the concerns, or report to Congress on what changes are necessary?

I have talked to my agencies about the 15-minute increment reporting that has to occur. They say the regulatory burden of the paperwork and the reporting, is so onerous that it has bogged down

the smallest of agencies. This reporting requirement is very, very difficult to comply with it, and they have to, but they are consumed by the burden of this paperwork.

I have another home health agency in Maine that began in 1994 to reclassify itself as a new agency. The year 1994 is being used to determine their reimbursement but as a result they are going to lose $780,000. This loss is devastating. I am trying to get an answer from HCFA on this situation and I am having difficulty.

I would like to be able to work with you and the Department on this issue because it seems to me that home health agencies are on the front lines of delivering care in this country. And if something is wrong with what we have done, we ought to recognize and deal with it. If it is also regulatory as well, we ought to address that. But I do not think we should just allow these problems to just continue, because we then lose agencies by default.

Secretary SHALALA. Senator Snowe, let me talk about the two points you made. First, the second point which is about a specific situation in Maine. Unfortunately, the date and the situation was written into law and would require a legislative change. We have already started working with your staff to identify what that change would be. We obviously would want to know what the cost would be to the system, but I do know the situation in Maine.

On the general issue of home health care, I was personally so alarmed at the stories that Senators and Members of the House were telling me that I sent teams of people to a number of States, including Tennessee, some rural States like New Mexico, and we have done some phone calls too. We are in the process of analyzing the data. I need to come back to Congress.

The law did essentially what Congress intended to do. You remember that home health care costs were spinning out of control. We transferred the part that did not have to do with hospitalization to Part B. And the first part, we actually—all of us believed that we needed to keep home health care closer to health. Therefore, a lot of the extra services, extra visits that were not as close to health services were in fact curbed.

For agencies that provided all those services that expected the health care system to pay for them, this meant that they were cutting back on the number of visits.

The question for us is, have we cut off access to needed services as a result of this? Not only what are we doing to the industry, but have we cut off access to needed services.

The GAO went out and looked and did not find that we had cut off access to services. I have asked for a more specific analysis because I want to report back to Congress and tell you what I think the concerns are.

But there is no question that the BBA was very specific, as I said previously. And the reason it was very specific was because you needed to get the savings so that you could do the balanced budget. We were part of that. Therefore, as far as I am concerned, if there are serious problems out there that ought to be corrected, we are all going to do it together. We will take an honest look.

But the key for us is access to services, whether people are no longer getting appropriate services. But my only warning here is that the Congress and the Administration intentionally wanted to

cut back on some things that were not necessarily directly related to health care. We think some of those social services ought to be included, but the question is whether medicare, the payroll tax, is going to assume that long term care burden as part of the Medicare System.

Senator SNOWE. I appreciate your response and I hope that we can work together.

Secretary SHALALA. I am happy to work with you on the specific Maine issue, and I know we have already started to work with your staff.

Senator SNOWE. Thank you.

Senator FRIST. Madam Secretary, thank you. There are a number of other questions, and although the title was the status of the Medicare Trust Funds, obviously we go right to the integrity of the Medicare Program whenever we talk about the trust funds, and I think that is very appropriate.

Academic health centers, I just want to again throw it out, take this opportunity and hope that the President will address that in his proposal. I believe that our continued support of academic health centers that really do train the quality of provider that we have today, in many ways is our salvation as we go forward through rocky times. We have too many people uninsured, over 40 million people uninsured, which is a problem that we must address. As we have people leaving the profession now because of problems that we create in terms of managed care, the private sector, and the public sector, that in many ways that workforce is the backbone of what makes America great.

The academic health centers are being squeezed by the private sector, by managed care, by the loss of cross-subsidization, and are very much dependent on sources of funding provided by medicare. It is an issue that I want to again put on the forefront because I have had the opportunity to see what academic health centers and the training of that workforce mean to American medicine, and think that in many ways is what will sustain us through these difficult times with an evolving and changing Medicare System, and Medicaid System, and private sector.

I know you are very committed to that, and look forward to working with you. That and graduate medical education.

I know our vote has got about 2 minutes left and I must to get over there, so let me just close and say thank you. And again, we enjoy working with you and we will all continue to work together as we go forward to do what is right for our senior citizens and individuals with disabilities.

Thank you very much.

[Whereupon, at 11:54 a.m., the committee was adjourned.]

PREPARED STATEMENT OF SENATOR SLADE GORTON

I am deeply disappointed in the Administration's proposals for medicare. Instead of leadership, it seems that the Administration has decided to take the same approach of reducing payments to providers in the fiscal year 2000 budget which will simply exacerbate the problem of access to quality health care services for Washington State's seniors and disabled.

I heard just yesterday from Washington's long term care community about the difficulty they are having treating high cost patients under the current reimbursement scheme. While I was home in the State, hospitals in rural communities echoed those

concerns. They are finding it difficult to find facilities that can take high cost patients under the current system without going broke. And the answer from the Administration is to implement new user fees and require more paperwork?

In the Balanced Budget Act (BBA) of 1997, hospitals and health systems were asked to shoulder $44 billion in medicare reductions over 5 years. Washington's 92 hospitals—all but six of which are not-for-profit—will have to bear $650 million of these payment reductions. Audited data from our State's Department of Health show that in 1997, 38 percent of Washington's hospitals lost money on operations. Preliminary data for 1998 indicate that losses will be higher. This means that many hospitals will have to cut staffing levels, will lose much of their ability to finance hospital improvements, and may be forced to close some facilities.

Hospitals represent only part of the crisis. In 1997 Washington health plans lost a combined $110 million. Nine of the ten largest plans experienced an operating loss, and six of them had net losses even after factoring in investment gains obtained in one of the strongest markets in the history of our Nation.

Washington State has one of the most efficient health care systems in the Nation. Our inpatient hospital costs are thousands of dollars—or 31 percent—less per-patient episode than the national average. Additionally, every county in Washington receives an adjusted average per capita cost (AAPCC) rate that's below the national average. In fact, those low reimbursement rates were one reason a number of insurance companies across Washington State dropped seniors from their health plans. This has meant that in many counties in Eastern Washington, seniors have no other option other than the more expensive fee-for-service plans. Across the board medicare cuts will only exacerbate the geographic inequities that currently plague the Medicare System and punish the Nation's more efficient providers.

Preserving medicare for current beneficiaries and future generations while improving access to quality health care is a daunting challenge. I am committed to it, but future reforms must not solely be at the expense of providers and must not punish efficient practices as is the case in the current system. I look forward to working with you to ensure that future reforms maintain the quality and accessibility of health care for seniors in Washington State.

Opening Statement of Senator Olympia J. Snowe

I am pleased to welcome Secretary Donna Shalala back to the Senate Budget Committee. And like my colleagues, I am pleased that our Nation's economy is in such good shape right now that the solvency of the Medicare Trust Fund was recently extended by 7 years. But we must ask ourselves what extending the solvency of the trust fund really means. Is medicare in a good financial position? Can we guarantee that this program will be around for years to come?

Medicare is in no way saved by the adjustment of a few numbers. There continues to be a huge crisis in medicare funding. As my esteemed colleagues know, medicare is already spending more than it brings in—and has been since 1992. Unfortunately, the trustee's recent projections cannot change that fact.

Mr. Chairman, there are many issues where Members of the Senate may disagree, but there is one stark fact—the fact that the Medicare Part A Trust Fund will be broke by 2015—which everyone in this room must accept. And the longer we wait to take meaningful steps to strengthen the program, the more difficult those solutions will be.

As my colleagues are aware, we didn't get a proposal out of the National Bipartisan Medicare Commission despite the best efforts of several members of this committee. But that "hung jury" decision does not mean we can simply ignore the fact that the Medicare Program—which is the program more then 38 million elderly Americans rely on for their health care—is going broke.

Fortunately, both the Senate Budget Committee and the Senate Finance Committee are already taking action to preserve and protect medicare. In addition, the President—whose committee appointees prevented the Commission from getting the final, crucial vote necessary to report a recommendation—has now said that he will send us his own proposal soon.

While we are concerned with the long-term stability of medicare, we must also be concerned with the efficacy of this complicated system. When medicare was created in 1965 it followed the private health insurance model of the time—inpatient health care. Today, 34 years later, it is sadly out of date. And one of the most glaring flaws in medicare is the lack of a comprehensive prescription drug benefit for its beneficiaries.

Mr. Chairman, I believe the cost of medicare prescription drugs constitutes a crisis for our senior citizens. While the President expressed support for such a benefit in the State of the Union, he failed to deliver anything for it in his budget proposal.

I hope to hear today from Secretary Shalala any of the details in the President's working proposal.

As my colleagues are well aware, this year's budget resolution contains a reserve fund for medicare and prescription drugs. Frankly, I believe that this reserve fund is one of the most critical items included in this year's Senate budget. Put simply, this reserve fund—that was adopted with nearly unanimous support by this committee—will provide the Congress with a critically needed opportunity to address an issue that has been highlighted repeatedly of late: the long-term solvency of medicare and a means to fund a new medicare prescription drug benefit.

Even as the reserve fund will help spur action on legislation to credibly extend the solvency of the Medicare Program, it will also allow us to take a critical step in improving and updating the Medicare System: the addition of a meaningful medicare prescription drug benefit. I believe this addition is, unquestionably, the most significant we could make to medicare as we seek to strengthen the system.

The lack of a prescription drug coverage benefit is the biggest hole—a black hole really—in the Medicare System. Though those over 65 years of age only make up 12 percent of the U.S. population, they account for a third of the national drug expenditures. HCFA will tell you that up to 65 percent of medicare beneficiaries have drug coverage from sources other than medicare. But that number simply doesn't tell the whole story and hides the true state of our elderly's access to adequate prescription drug insurance.

The focus of the proposal I am working on with my esteemed colleague from Oregon, Senator Ron Wyden, will provide senior citizens with actual coverage for prescription drugs.

I believe it is critical that we make it possible to strengthen and improve medicare in the Congress. The reserve fund already contained in the budget may be our best hope to repair and improve the Medicare Program. It will allow it be one our finest accomplishments in the 106th Congress—not a political punching bag that delivers nothing of value to our deliberations or to our Nation's elderly. And I am very much looking forward to Secretary Shalala's analysis of the state of medicare and to the possibility of a prescription drug proposal from President Clinton.

Opening Statement of Senator Patty Murray

Mr. Chairman.

I am pleased that you have scheduled a hearing on the more recent Social Security and Medicare Trustees' Report. There is no doubt that reform of both Social Security and medicare represent the greatest challenges facing this Congress. However, reform also gives us a tremendous opportunity to restore integrity to the programs and update programs that have not been significantly altered since their inception.

I am particularly interested in the Trustees findings for the Hospital Insurance Trust Fund. I believe we need to deal with medicare now and then tackle Social Security reform. Medicare poses the most immediate threat to our seniors and current workers who will be tiring within the next 10 years.

In the summary of the Annual Reports, the Trustees point out that medicare costs are increasing both because new, more expensive and effective medical technology is being developed every year and because of the health care needs of an aging U.S. population.

My question for Secretary Shalala pertains to this statement from the Trustees report. Since the early 1980's we have fought hard to improve medicare benefits and increased our focus on prevention and diagnosis benefits. We have seen the coverage for mammogram, colerectual screening and expanded home health care benefits added to the medicare basic benefits package. I believe that these benefits ultimately save medicare dollars and contribute to a healthier senior population. While there are initial costs, there are long term savings.

Couldn't one conclude that more effective medical technology or increased prevention benefits ultimately makes medicare stronger financially? While new drug therapies or new technology may have initial costs, I don't believe that it is wise to simply say that medicare costs are increasing because of the availability of new more effective medical technology.

Could the Secretary respond?

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